Department of Mental Health

TRANSMITTAL LETTER

SUBJECT Continuity of Care Practice Guidelines for Children and Youth		
POLICY NUMBER **DMH Policy 200.5**	DATE MAY 1 1 2007	TL# 88

Purpose. To establish specific guidelines for the continuity of care between providers of mental health services and supports to Department of Mental Health (DMH) child/youth consumers. ***This issuance separates the continuity of care practice guidelines for children and youth from the original guidelines that applied to all consumers.***

Applicability. Applies to core services agencies (CSAs), private hospitals, contractors (including Residential Treatment Centers), and the Mental Health Authority; and all other providers who have an agreement or contract with DMH or with certified providers regarding provision of services for DMH child/youth consumers.

Policy Clearance. Reviewed by affected responsible staff and cleared through appropriate MHA offices.

Implementation Plans. **A plan of action to implement or adhere to this policy must be developed by designated responsible staff. If materials and/or training are required to implement this policy, these requirements must be part of the action plan. Specific staff should be designated to carry out the implementation and program managers are responsible for following through to ensure compliance. Action plans and completion dates should be sent to the appropriate authority. Contracting Officer Technical Representatives (COTRs) must also ensure that contractors are informed of this policy if it is applicable or pertinent to their scope of work.** ***Implementation of all DMH policies shall begin as soon as possible. Full implementation of this policy shall be completed within sixty (60) days after the date of this policy.***

Policy Dissemination and Filing Instructions. Managers/supervisors of DMH and DMH contractors must ensure that staff are informed of this policy. Each staff person who maintains policy manuals must ensure that this policy is filed in the **DMH** Policy and Procedures Manual, and contractors must ensure that this policy is maintained in accordance with their internal procedures.

*If any CMHS or DMH policies are referenced in this policy, copies may be obtained from the DMH Policy Support Division by calling (202) 673-7757.

ACTION

REMOVE AND DESTROY	INSERT
None	DMH Policy 200.5

Stephen T. Baron
Director, DMH

GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF MENTAL HEALTH	Policy No. 200.5	Date MAY 1 1 2007	Page 1
	Supersedes: None		

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1. **Purpose**. To establish specific guidelines for the continuity of care between providers of mental health services and supports to Department of Mental Health (DMH) child/youth consumers. ***This issuance separates the continuity of care practice guidelines for children and youth from the original guidelines that applied to all consumers.***

2. **Applicability**. Applies to core services agencies (CSAs), private hospitals, contractors (including Residential Treatment Centers), and the Mental Health Authority; and all other providers who have an agreement or contract with DMH or with certified providers regarding provision of services for DMH child/youth consumers.

3. **Authority**. Department of Mental Health Establishment Amendment Act of 2001.

4. **Definitions/Abbreviations**. For purposes of this policy:

4a. DMH Continuity of Care Practice Guidelines for Child/Youth Providers in the Mental Health System of Care - guidelines that describe the responsibilities and actions of providers and DMH in response to child/youth consumers who seek or receive urgent or emergency mental health treatment and supports and/or transfer, or who are discharged to different levels of care within the mental health system, or admitted to a Residential Treatment Center (RTC).

4b. Mental Heath Provider - referred to in this policy as provider, is: (a) any individual or entity, public or private, that is licensed or certified by the District of Columbia to provide mental health services or mental health supports; or (b) any individual or entity, public or private, that has entered into an agreement with DMH to provide mental health services or mental health supports.

4c. Private Hospitals - those private hospitals in the District of Columbia that have arrangements with the DMH for provision of services to DMH child/youth consumers.

5. **Policy**. To ensure continuity of care, all providers who serve children and youth will follow the DMH Continuity of Care Practice Guidelines for Child/Youth Providers in the Mental Health System of Care for the provision of urgent or emergency mental health services.

6. **Responsibilities for DMH**. DMH shall:

6a. **Issue** continuity of care practice guidelines to all newly certified child/youth providers and to other organizations as described in the guidelines who are involved in their care (e.g., CFSA);

6b. **Notify** providers of all changes to the continuity of care practice guidelines as soon as the changes become effective; and

6c. **Monitor** treatment and care in compliance with the continuity of care practice guidelines, and take appropriate action where necessary.

7. **Specific Guidance for All Child/Youth Providers**.

7a. **Utilize** the DMH Continuity of Care Practice Guidelines for Child/Youth Providers in the Mental Health System of Care (Exhibit 1) for urgent, emergency, transfer, and admission and discharge situations when a child/youth consumer:

(1) needs mobile crisis services or an assessment by a site based psychiatric emergency services facility or an acute care facility;

(2) presents for treatment at a Core Services Agency (CSA);

(3) presents for treatment at a provider who is not a CSA;

(4) is assigned to the provider via the Access Helpline;

(5) is admitted to or discharged from an acute care facility;

(6) transfers to another CSA; and

(7) is admitted to a Residential Treatment Center (RTC).

7b. **Adhere** to DMH clinical policies, including DMH Policy 300.1, Level of Care Utilization System (Locus/Calocus) Evaluations; and DMH Policy 645.1, DMH Privacy Policies and Procedures.

7c. **Link** the child/youth to resources that are most relevant to the consumer's identified needs. The provider shall link the consumer to these services, rather than having the consumer locate their own services; and

7d. **Be Familiar** with the continuity of care practice guidelines for children and youth and all subsequent revisions as they become available to ensure continuity of care.

Approved By:

Stephen T. Baron
Director, DMH

5/11/07

(Signature) **(Date)**

District of Columbia Department of Mental Health
Continuity of Care Practice Guidelines
for *CHILD/YOUTH* Providers in the Mental Health System of Care

These guidelines outline the responsibilities of the District of Columbia Department of Mental Health (hereafter called DMH) system of care providers for children/youth and their families.

The following sections describe the responsibilities and actions of providers and the DMH Division of Care Coordination Access Helpline in response to child/youth consumers who seek or receive urgent or emergency mental health treatment and supports and/or transfer to different levels of care within the system of care. The outline below describes the structure of these guidelines.

1. Crisis Response, Urgent and Emergency Care
   - 1A. Presentation at a Provider who is not a Core Services Agency (CSA)
   - 1B. Contacting the DMH Access Helpline (AHL)
   - 1C. Response by Mobile Crisis Services
   - 1D. Assessment by a Site Based Psychiatric Emergency Services Facility or an Acute Care Facility
   - 1E. Presentation at a Provider who is a CSA

2. Continuity of Care Upon Admission to an Acute Care Facility
   - 2A. If the Consumer has a CSA
   - 2B. If the Consumer has no CSA and is Eligible for CSA Enrollment
   - 2C. Responsibilities of the Acute Care Facility

3. Continuity of Care for Admission to a Residential Treatment Center (RTC)
   - 3A. If the Child/Youth is under the Custodial Care of Child and Family Services Agency (CFSA)
   - 3B. If the Child/Youth has no connection to CFSA
   - 3C. If the Child/Youth is placed by other District Placing Agencies (Department of Youth and Rehabilitation Services [DYRS], DC Public Schools [DCPS], and Managed Care Organizations [MCOs])
   - 3D. Responsibilities of the RTC

4. Continuity of Care for any CSA Transfer/Change
   - 4A. Right to Change a CSA
   - 4B. Responsibilities upon Knowledge of Child/Youth's Intent to Transfer or Change CSA

5. Monitoring

6. Definitions

The provider shall adhere to DMH clinical policies, including DMH Policy 300.1, Level of Care Utilization System (Locus/Calocus) Evaluations; and DMH Policy 645.1, DMH Privacy Policies and Procedures.

District of Columbia Department of Mental Health
Continuity of Care Practice Guidelines
for *CHILD/YOUTH* Providers in the Mental Health System of Care

1. Crisis Response, Urgent and Emergency Care.

Consumers in crisis (who meet Mental Health Rehabilitation Services [MHRS] urgent or emergency care criteria) may first seek or be presented for treatment at several different locations. The provider's crisis response shall be consistent with the provider's role for that consumer, based on that consumer's need at that time, as described below:

1A. Presentation at a Provider who is not a Core Services Agency (CSA):

When a consumer presents or is presented at a provider that is not the consumer's CSA, the provider shall either call 911; contact AHL to request a mobile crisis response, as appropriate; or provide any needed emergency care to stabilize immediate life threatening situations, and then refer the consumer based on that provider's knowledge of that consumer's status.

1. Once stabilized, providers will direct a consumer who is not enrolled with a CSA to the DMH Access HelpLine (AHL) for linkage to a CSA per consumer or custodian choice.

2. If a consumer is already enrolled in a CSA, providers will notify AHL so that AHL can link the consumer to the appropriate CSA for a CSA follow-up appointment.

1B. Contacting the DMH Access HelpLine (AHL):

When a consumer or family member contacts the AHL or contact is made by another individual or entity, the AHL staff will complete the crisis assessment event screen in eCura, and determine if there is other agency involvement [e.g. Child and Family Services Agency (CFSA) or Department of Youth and Rehabilitation Services (DYRS)].

When the consumer's needs are identified as urgent or emergency, AHL will respond as follows:

1. If consumer has a CSA, AHL staff will contact the CSA utilizing the unscheduled access policy for that CSA, unless immediately calling 911 is indicated upon determination that the consumer is in imminent danger to self or others, or a referral for mobile crisis services is needed.

    a. If no response from CSA within thirty (30) minutes, page CSA again.

b. If no response from CSA within two (2) hours from first contact (or sooner based on assessed need), contact the CSA senior administrator or designee.

c. AHL staff may deploy mobile crisis services in the absence of a CSA response.

2. If consumer does not have a CSA, AHL will request response by mobile crisis services, unless immediately calling 911 is indicated upon determination that the consumer is in imminent danger to self or others.

3. AHL staff will document linkage to services and the planned action (e.g., inform the consumer that mobile crisis services will visit consumer) and notify DYRS or CFSA if applicable.

1C. Response by Mobile Crisis Services

1. Upon request from Access Helpline (AHL), mobile crisis services will respond within one (1) hour of the request or referral, and provide crisis/emergency services as appropriate. Crisis/emergency services consist of immediate response to screen the presenting mental health situation, de-escalation, and resolution of the immediate crisis situation.

The crisis response period for children and youth may extend up to 72 hours. During that time, mobile crisis services will continue to monitor the situation to de-escalate as required. Mobile crisis services will determine through AHL if the consumer has a CSA and, if so, communicate with the CSA regarding history and collaborate on a crisis plan.

2. Once mobile crisis services are completed, they will also ensure the consumer is connected to the appropriate level of care by: (a) notifying the consumer's CSA and ensuring follow-up services; or (b) through AHL, linking the consumer to a CSA, and ensuring follow-up services; or (c) notifying the CSA/AHL if the consumer will be admitted to a hospital.

3. If the consumer is discharged from crisis/emergency services for follow-up with a CSA, mobile crisis services will maintain contact with the consumer until the consumer's CSA has fully assumed responsibility for carrying out the treatment plan for the consumer.

4. If the child/youth needs an assessment for involuntary hospitalization, a mobile crisis services team member (who must be a physician, psychologist, or duly accredited officer or agent) will complete an FD-12, Application for Emergency

Hospitalization, and either transport, or arrange for transport of the child/youth for an assessment by a site based psychiatric emergency services facility or an acute care facility.

1D. Assessment by a Site Based Psychiatric Emergency Services Facility or an Acute Care Facility.

1. A consumer may present directly or be transported by mobile crisis services for an assessment.

2. If the consumer presents directly, the site based psychiatric emergency services facility or acute care facility must notify AHL of any child/youth that is enrolled/eligible for fee-for-service Medicaid (CFSA- and DYRS-committed children/youth or children/youth with SSI disability who are not enrolled in HSCSN [Health Services for Children with Special Needs]). For children/youth that have a Managed Care Organization (MCO), the MCO is responsible for all mental health case management services for enrolled children/youth.

3. Admission to an acute care facility may proceed if the facility's psychiatrist or qualified psychologist recommends admission based on medical necessity.

1E. Presentation at a Provider who is a Core Services Agency (CSA):

When a consumer presents in crisis at the consumer's CSA, the CSA will:

1. Provide any needed emergency care to stabilize immediate life threatening situations, which may include but is not limited to calling 911, and then refer consumer for further treatment based on that CSA's knowledge of that consumer's status;

2. Use these practice guidelines and/or Calocus/Locus screening to indicate level of acuity and appropriate service needs; and

3. If an enrolled consumer meets the guidelines for urgent or emergency need, initiate appropriate clinical intervention based on the assessed needs of the consumer.

a. CSA on-call staff will have access to IPC/IRP and crisis plan, and consult these plans for on-call responses;

b. Intervention will include a workable, behavior based plan for resolving the crisis including steps, outcomes, timeframes, and indication of when the next level of response should be initiated; and

c. Interventions shall be used to create or update the IPC/IRP, and/or crisis plan.

2. Continuity of Care Upon Admission to an Acute Care Facility [See Section 3 below for Residential Treatment Centers (RTCs)].

It is the responsibility of the acute care facility where the child is admitted to determine if the consumer is enrolled in a CSA. Upon the admission to an acute care facility, the protocol below will be followed.

2A. If the Consumer has a Core Services Agency (CSA):

1. The acute care facility will communicate with the consumer's CSA within one (1) business day of admission. The DMH Access Helpline will also notify the CSA of hospitalization.

2. The CSA clinical manager or approving practitioner for that consumer's IPC/IRP (or designated CSA representative with clinical knowledge of the consumer's current status/history) will have face to face contact with the consumer and designated acute care facility staff within two (2) business days of admission.

- Communication with designated facility staff will include discussion of the consumer's psychosocial history, IPC/IRP, treatment course history, medication history, and attendance at the initial treatment team meeting with facility staff to be held within five (5) calendar days of admission.

3. If the consumer is transferred to any other facility (for example: another acute hospital) after the original admission, the clinical manager or clinician designated in the consumer's IPC/IRP from the CSA will communicate with the new facility's designated staff within one (1) business day after transfer, and notify the DMH Access HelpLine (AHL) within two (2) business days.

4. Once transferred, the CSA clinical manager or approving practitioner for that consumer's IPC/IRP (or designated CSA representative with clinical knowledge of the consumer's current status/history) will have face to face contact with the consumer and the new acute care facility staff within two (2) business days after transfer.

- Communication with facility staff will include the discussion of consumer's psychosocial history, IPC/IRP, treatment course history, medication history, and scheduling of initial treatment team meeting with new facility's staff.

5. During the time of treatment in the acute care facility, the clinical manager from the CSA, or clinician designated in the consumer's IPC/IRP, shall:

a. Ensure Calocus/Locus screenings are performed at appropriate intervals to indicate level of acuity and appropriate service needs;

b. Have face to face contact with consumer twice a week for the first thirty (30) days of stay at the facility;

c. Have face to face contact with the consumer once a week for subsequent lengths of stay at the facility;

d. Make contact with significant others as noted on the IPC/IRP to notify of admission the same day of admission if possible, and no later than the following day;

e. Make contact with the facility treatment team at an initial treatment team meeting. This treatment team meeting must include discharge planning with the consumer, the consumer's family as appropriate, and the facility treatment team;

f. Make contact with the facility treatment team weekly thereafter, this may include attendance at subsequent treatment planning meetings; and

g. Ensure attendance by at least one (1) member of the CSA treatment team at the facility's regular treatment planning meetings for that consumer.

6. The CSA clinical manager or clinician designated in the consumer's IPC/IRP, will develop discharge planning with the consumer and acute care facility staff, which will address individual community service and support needs, including benefits acquisition and housing resources, as documented in the IPC/IRP.

7. CSA staff will maintain progress notes in the clinical record at the CSA, reflecting all meetings and communications with facility staff, the consumer, and all significant others. If appropriate, the CSA treating psychiatrist will consult by telephone or in person with the acute care facility-treating psychiatrist.

8. Discharge planning and documentation must include:

a. A scheduled medication somatic appointment for all consumers on psychotropic medications with the CSA within ten (10) business days of discharge;

b. A face to face meeting between the clinical manager, or clinician designated in the consumer's IPC/IRP, and the consumer, preferably within one (1) business day (but no later than 2 business days) of the consumer's discharge from facility to the community; and

c. Evidence of an attempt to address the consumer's individual needs including benefits acquisition, education, placement, and housing, as applicable.

2B. If Consumer has no Core Services Agency (CSA) and is Eligible for CSA Enrollment:

1. The acute care facility staff where the child/youth is admitted will notify the DMH Access HelpLine (AHL) of the admission and lack of an assigned CSA of any child/youth that is enrolled/eligible for fee-for-service Medicaid (CFSA- and DYRS-committed children/youth or children/youth with SSI disability who are not enrolled in HSCSN [Health Services for Children with Special Needs]). For children/youth that have a Managed Care Organization (MCO), the MCO is responsible for all mental health case management services for enrolled children/youth.

2. The AHL staff will enroll the consumer with a CSA if the consumer/consumer's parent/legal guardian is able and willing to have a telephone conversation. This will be done with the consumer choice process. If the consumer/consumer's parent/legal guardian is unable or unwilling to have this telephone contact, a CSA will be randomly assigned.

- If random CSA assignment occurs, the CSA will be responsible for ensuring that the choice menu form is completed when the consumer is more stable, and filed in the consumer's clinical record.

3. The assigned CSA is responsible for retrieving enrollment notification from Provider Connect. The AHL will also notify the assigned CSA of admission of the consumer and their enrollment to the CSA by telephone and email within twenty-four (24) hours so that the CSA can begin the discharge planning process from the acute care facility.

4. The CSA will have face-to-face contact with consumer within two (2) business days of the consumer being assigned to that CSA.

5. The CSA will become responsible for fulfilling the CSA responsibilities as detailed in Section 2, Continuity of Care Upon Admission to Acute Care Facility, 2A, 5-8 above.

2C. Responsibilities of the Acute Care Facility:

Upon admission, the acute care facility will communicate with the consumer's CSA within one (1) business day of admission and perform the following responsibilities for the consumer's continuity of care. Acute care facilities have additional

responsibilities, such as those imposed by District and federal laws including the Ervin Act.

1. The acute care facility will schedule the initial treatment team meeting to be held within five (5) calendar days of admission to the facility, and document invitation of CSA representative. The initial treatment team meeting will include tentative plans for discharge.

2. The acute care facility will ensure the consumer's/consumer's parent/legal guardian's attendance at all treatment team meetings, and every discharge planning meeting.

   a. In situations where the consumer does not demonstrate capacity to attend such meetings, or does not wish to attend, the facility shall record in the clinical record, the reason the consumer did not attend; and

   b. The acute care facility staff must document each time an attempt was made to include the consumer, for every date where a consumer did not attend.

3. The acute care facility shall notify the CSA immediately of any transfer or unplanned discharge.

4. At discharge, the acute care facility will provide a prescription or enough medication for the consumer until the next scheduled medication somatic appointment scheduled at their CSA, or as determined in the discharge planning process.

3. Continuity of Care for Admission to a Residential Treatment Center (RTC).

In order for the placement to be Medicaid eligible (if the child/youth is not placed by a managed care organization), DMH must certify the medical necessity of admission to an RTC. A goal of the system of care is to ensure that every opportunity to place a child/youth in the community is exercised before an RTC placement recommendation is made. The Family Team Conference (FTC) process should ensure that all diversion opportunities occur before making a recommendation to place the child/youth in an RTC.

3A. The following applies when DMH certifies the medical necessity for RTC placement of a child/youth who is under the custodial care of Child and Family Services Agency (CFSA).

- Refer to Section 3B below when the child/youth has no connection to CFSA.
- Refer to Section 3C below when the child/youth is placed in an RTC by other District placing agencies (e.g., Department of Youth and Rehabilitation Services [DYRS], DC Public Schools [DCPS], and Managed Care Organizations [MCOs]).

1. **If the Child/Youth has a CSA** (and is under the custodial care of CFSA):

a. The DMH Child and Youth Services Division (DMH CYSD) will ensure that the child/youth's CSA is notified of the Family Team Conference.

b. If DMH certifies the medical necessity for an RTC placement, the CSA shall collaborate with CFSA who will identify the RTC. The CSA will communicate with the RTC and provide the RTC with a summary of the child/youth's course of treatment, medication history, IPC/IRP, and goals for RTC placement.

c. DMH CYSD staff will coordinate with the CSA to ensure that communication between CFSA, CSA, and RTC is complete, and to ensure that the RTC has all relevant information to initiate treatment planning for the child/youth.

d. The CFSA will be responsible for transportation and ensure relocation and placement of the child to the RTC, including a face-to-face meeting with the child/youth and the RTC treatment team.

e. During the course of the placement, DMH CYSD will ensure that all relevant information with respect to the plan of treatment and progress of the child/youth is communicated to the CSA at least every ninety (90) days or as otherwise appropriate.

f. DMH CYSD is responsible for monitoring the appropriateness of the clinical program/treatment during the CFSA child/youth's RTC placement. DMH CYSD and CFSA will participate in the initial treatment team meeting at the RTC facility within seven (7) calendar days of admission. DMH CYSD and CFSA will participate in the initial treatment team meeting telephonically if face-to-face participation is not feasible. DMH and CFSA will conduct concurrent on-site reviews whenever feasible and share information throughout the placement, working jointly to effect timely discharge planning that assures appropriate services and supports are engaged and ready to assist the youth with reintegration into the home and community.

i. The initial treatment team meeting will include establishment of a tentative discharge plan and such plan will be monitored and updated as appropriate at subsequent treatment team meetings, which DMH CYSD will monitor no less than every ninety (90) days.

ii. DMH CYSD and CFSA shall participate in quarterly treatment team meetings telephonically if face-to-face participation is not feasible.

iii. No less than ninety (90) days prior to the child/youth's discharge, DMH CYSD and CFSA will begin planning with the RTC and the CSA to effect the smooth transition and coordination of care for the returning child/youth. Such planning will include: community service and support needs; parent/caregiver's access to services, as appropriate; benefits acquisition; education, placement and housing resources as appropriate; and other mental health services and supports that are identified in the discharge plan.

iv. DMH CYSD will document all participation in treatment planning and care coordination activities in the clinical record, and coordinate discharge planning with the CSA.

g. Discharge planning and documentation must include:

i. A scheduled medication somatic appointment for each child/youth on psychotropic medications with the CSA within ten (10) business days of discharge; and

ii. A face to face meeting between the CSA, DMH Child and Youth Services Division (DMH CYSD), CFSA, and the child/youth and his or her parent/legal guardian/caregiver preferably within one (1) business day (but no later than 2 business days) of the child/youth's return to the community.

2. **If Child/youth has no CSA** (and is under the custodial care of CFSA):

a. The Child and Family Services Agency (CFSA) will contact the DMH Child and Youth Services Division (DMH CYSD). The DMH CYSD will schedule the Family Team Conference for determination of appropriate services (e.g., community based, RTC).

If DMH certifies the medical necessity for an RTC placement, CFSA will identify the RTC and provide the RTC with a summary of the child/youth's care and treatment and medical history. DMH CYSD and the CFSA will be responsible for placement and monitoring as stated in 3A1 except the child/youth will not be linked to a CSA until discharge planning begins.

b. CFSA will ensure the child/youth is linked to a CSA no less than ninety (90) days prior to the child/youth's discharge. CFSA Behavioral Services Unit will work with the CFSA social worker regarding choice of a CSA. DMH CYSD staff member will ensure that the choice is documented on a referral form at the first discharge planning meeting and ensure that a copy of the signed choice menu form is provided to the selected CSA.

c. Based on the consumer choice process, the AHL staff will assign a CSA and notify the CSA of the enrollment within twenty-four (24) hours.

d. The CSA will participate in discharge planning/coordination of care activities as stated in Section 3A1 above.

3B. The following applies if the child/youth has no connection to CFSA:

1. **If the Child/Youth has a CSA:**

a. The DMH Child and Youth Services Division (DMH CYSD) will ensure that the child/youth's CSA is notified of the Family Team Conference.

b. If DMH certifies the medical necessity for an RTC placement, the CSA will collaborate with DMH who will work with the consumer's parent/caregiver to identify the RTC. The CSA will provide the RTC with a summary of the child/youth's course of treatment, medication history, IPC/IRP, and goals for RTC placement.

c. DMH CYSD staff will coordinate with the CSA to ensure that communication between the CSA and RTC is complete, and to ensure that the RTC has all relevant information to initiate treatment planning for the child/youth.

d. DMH will support parent/caregiver in making transportation arrangements, including accompanying parent/caregiver and consumer, and participating in face-to-face meeting with the child/youth and the RTC treatment team.

e. During the course of the placement, DMH CYSD will ensure that all relevant information with respect to the plan of treatment and progress of the child/youth is communicated to the CSA at least every ninety (90) days or as otherwise appropriate.

f. DMH CYSD is responsible for monitoring the appropriateness of the clinical program/treatment during the child/youth's RTC placement. DMH CYSD will participate in the initial treatment team meeting at the RTC facility within seven (7) calendar days of admission. The DMH CYSD will participate telephonically if face-to-face participation is not feasible.

i. The initial treatment team meeting will include establishment of a tentative discharge plan and such plan will be monitored and updated as appropriate at subsequent treatment team meetings, which DMH CYSD will monitor no less than every ninety (90) days.

ii. The DMH CYSD shall participate in quarterly treatment team meetings telephonically if face-to-face participation is not feasible.

iii. No less than ninety (90) days prior to the child/youth's discharge, DMH CYSD and the CSA will begin planning with the RTC to effect the smooth transition and coordination of care for the returning child/youth. Such planning will include: community service and support needs; parent/caregiver's access to services, as appropriate; benefits acquisition; education, placement and housing resources, as appropriate; and other mental health services and supports that are identified in the discharge plan.

iv. The DMH CYSD will document all participation in treatment planning and care coordination activities in the clinical record, and communicate with the CSA staff regularly as necessary and/or appropriate.

g. Discharge planning and documentation must include:

i. A scheduled medication somatic appointment for each child/youth on psychotropic medications with the CSA within ten (10) business days of discharge; and

ii. A face to face meeting between the CSA and DMH CYSD staff and the child/youth and his or her parent/legal guardian/caregiver preferably within one (1) business day (but no later than 2 business days) of the child/youth's return to the community.

2. If Child/youth has no CSA (and has no connection to CFSA):

a. The DMH Child and Youth Services Division (DMH CYSD) will schedule the Family Team Conference for determination of appropriate services. If DMH certifies the medical necessity for RTC placement, DMH CYSD will be responsible for overall placement, provision of information on the child/youth's previous care and treatment, and monitoring. DMH CYSD will ensure the child/youth is linked to a CSA through AHL no less than ninety (90) days prior to the child/youth's discharge.

b. The CSA will participate with DMH CYSD and the RTC in discharge planning/coordination of care activities as stated in 3B1 above.

3C. For Other District Placing Agencies (e.g., DYRS, DCPS, and MCOs), each agency is responsible for overall placement, monitoring, and discharge planning. DMH CYSD may perform the clinical oversight for a District placing agency and help support discharge planning through a memorandum of understanding (MOU).

3D. Responsibilities of the Residential Treatment Center (RTC):

Responsibilities of the RTC are covered in federal and District regulatory mandates and contractual agreements.

4. Continuity of Care for any CSA Transfer/Change.

4A. Right to Change a CSA: A child or youth/parent/legal guardian has the right to change the child/youth's CSA at any time for any reason or for no reason. This change may be made by telephone call to the DMH Access HelpLine (AHL), or via CFSA email. AHL staff will close the current enrollment and open enrollment with the new CSA. A consumer's change of CSA will be effective at midnight of the following day from the date of the change request call to the AHL. Three (3) changes of CSA by a consumer within a benefit year will trigger a Care Coordination utilization review.

4B. Responsibilities upon Knowledge of Child/Youth's Intent to Transfer or Change CSA:

1. When a child or youth/parent/legal guardian notifies the CSA clinical manager/approving practitioner of his/her decision to change CSAs, the transferring CSA clinical manager/approving practitioner will:

   a. Educate the consumer as to all available CSAs and their services, but may neither recommend nor suggest a CSA; and

   b. Assist the consumer, if he/she so desires with visiting the other CSAs and meeting with a representative from each CSA.

2. When the child or youth/parent/legal guardian makes a choice as to the new CSA he/she wants to receive services from, the transferring CSA clinical manager/approving practitioner will:

   a. Contact the new CSA to notify the new CSA of the consumer's decision to transfer.

   b. Assist the consumer with contacting the AHL to arrange for transfer.

3. If the consumer completed and signed DMH-HIPAA Form 2, Consent for the Use and Disclosure of Protected Health Information Among Participating Network Providers, the CSA clinical manager/approving practitioner (or designated CSA representative with clinical knowledge of the consumer's current status/history) will meet face to face with the new CSA clinical manager/approving practitioner within one (1) week of the transfer to the new CSA.

   - If the child/youth agrees, he/she and the child/youth's parent/legal guardian will also attend this meeting so that the transferring CSA can introduce him/her to the new CSA clinical manager/approving practitioner.

4. If the consumer completed and signed a DMH-HIPAA Form 2 Consent for the Use and Disclosure of Protected Health Information Among Participating Network Providers, send the following documentation to the new CSA within one (1) week of the transfer:

i. Diagnostic assessment;

ii. IPC/IRP and ISSP;

iii. Clinical manager/approving practitioner's progress notes for past six (6) months;

iv. Psychiatrist's progress notes for past six (6) months; and

v. Current medication records including lab reports, and physical.

5. If the consumer refuses to sign a DMH-HIPAA Form 2, Consent for the Use and Disclosure of Protected Health Information Among Participating Network Providers, for sharing records, the new CSA clinical manager/approving practitioner will discuss with the consumer the importance of the sharing of information and present options to the consumer to sign a limited authorization of disclosure (DMH-HIPAA Form 3, Authorization to Use or Disclose Protected Health Information). This may mean educating the consumer as to what portions of the record would be acceptable to transfer to the new CSA.

6. If the consumer transfers to a new CSA without first notifying the previous CSA, both agencies will learn of this via the eCura system. When this occurs, the previous CSA will ensure the consumer signed an authorization for disclosure form and then follow the same procedures in 4B 3 and 4 above. If the consumer refuses to sign an authorization for disclosure, the new CSA will follow 4B 5 above.

5. **Monitoring**. The DMH Division of Care Coordination will monitor compliance with the Continuity of Care Practice Guidelines including provider responsiveness when paged or called regarding a crisis/emergency situation and continuity of care responsibilities regarding consumer's change in level of care. Appropriate actions will be taken as necessary.

6. **Definitions**. For purposes of these Child and Youth Continuity of Care Guidelines:

Acute Care Facility – private hospitals at which acute or crisis mental health services are provided, also referred to as "facility" in this document.

Approving Practitioner – the qualified practitioner responsible for overseeing the development of and approval of the IRP or IPC. The approving practitioner serves on the diagnostic/assessment team and may also serve as the clinical manager.

Authorization Plan – items from the ISSP and the IRP/IPC that are entered into eCura and Provider Connect and result in authorization plan numbers.

Child and Family Services Agency (CFSA) – The District agency responsible for the coordination of foster care, adoption and child welfare services and services to protect children against abuse or neglect.

CALOCUS - Child and Adolescent Level of Care Utilization System assessment tool.

Child(ren)/Youth - Children or youth with mental health problems includes persons under 18 years of age, or persons under 22 years of age and receiving special education, youth or child welfare services, who:

> (1) Have, or are at risk of having, a diagnosable mental, behavioral, or emotional disorder (including those of biological etiology) which substantially impairs the mental health of the person or is of sufficient duration to meet diagnostic criteria specified within the DSM-IV or the ICD-9-CM equivalent (and subsequent revisions), with the exception of substance abuse disorders, mental retardation, and other developmental disorders, or seizure disorders, unless those exceptions co-occur with another diagnosable serious emotional disturbance; and
>
> (2) Demonstrate either functional impairments or symptoms that significantly disrupt their academic or developmental progress or family and interpersonal relationships; or
>
> (3) Have an emotional disturbance causing problems so severe as to require significant mental health intervention.

Clinical Manager –the qualified practitioner chosen by the consumer to coordinate service delivery. The clinical manager shall participate in the development and review of the consumer's IRP/IPC, along with the approving practitioner. The clinical manager may also serve as the approving practitioner. The clinical manager shall be employed by the CSA, except that a psychiatrist serving as a clinical manager may be under contract to the CSA.

Consumer – a person who is eligible to receive MHRS as defined in the District of Columbia, Department of Mental Health Establishment Congressional Review Emergency Amendment Act of 2001, effective July 23, 2001 (D.C. ACT 14-101). "Consumer" in this document refers to the child/youth, and implies the consent and involvement of his/her parent legal guardian. The child/youth's parent or legal guardian on behalf of the child/youth may secure services.

Core Services Agency (CSA) – a DMH certified community-based MHRS provider that has entered into a Human Care Agreement with DMH to provide specified MHRS. A CSA shall provide at least one core service directly and may provide up to three core services via contract with a sub-provider or subcontractor. A CSA may provide specialty services directly if certified by DMH as a specialty provider. However, a CSA shall also offer specialty services via an affiliation agreement with all specialty providers.

District of Columbia Public Schools – referred to as DCPS.

DMH Access HelpLine (AHL) –a telephone-based service center operated by DMH twenty-four hours per day, seven days per week (24/7). The DMH Access HelpLine, 888-7WE-HELP (888-793-4357), provides crisis intervention, information and referral, service authorization and eligibility and enrollment to the DMH system of care.

Department of Youth Rehabilitative Services (DYRS) – The District agency responsible for providing security, supervision and residential and community support services for committed and detained juvenile offenders and juvenile persons in need of supervision.

Emergency Need – for consumers who are involved in active crisis where the safety of the consumer or others is at risk within the next twenty-four (24) hours. Safety may be at risk due to suicide, homicide, and/or severe decompensation of functioning. Face to face services must be provided within one (1) hour of presentation at a CSA. Mobile crisis services must be provided within one (1) hour of the request or referral.

Individual Plan of Care (IPC) - the individualized plan of care for child/youth consumers, which is the result of the diagnostic/assessment. The IPC is maintained by the consumer's CSA. The IPC includes the consumer's treatment goals, strengths, challenges, objectives, and interventions. The IPC is the authorization of treatment, based on certification that the MHRS are medically necessary by the approving practitioner.

LOCUS – Level of Care Utilization System for psychiatric and addiction services, adult version assessment tool.

Managed Care Organization – referred to as MCO.

Mental Heath Provider– (a) any individual or entity, public or private, that is licensed or certified by the District of Columbia to provide mental health services or mental health supports, or (b) any individual or entity, public or private, that has entered into an agreement with DMH to provide mental health services or mental health supports, also referred to in these guidelines as "provider."

Mental Health Rehabilitation Services (MHRS) – those mental health services performed by DMH certified providers, according to the Mental Health Rehabilitation Services Provider Certification Standards; Chapter 34 of Title 22A District of Columbia Municipal Regulations.

Natural Settings – the consumer's residence, workplace, or other locations in the community the consumer frequents, such as the consumer's home, school, workplace, community centers, homeless shelters, street locations, or other public facilities. Natural settings do not include inpatient hospitals or community residential facilities.

Residential Treatment Center (RTC) – private facilities that provide site based, residential treatment for children/youth in need of structured, twenty-four hours per day, seven days per week (24/7), out-of-home treatment of acuity not necessitating acute care.

Routine Need – CSAs response time of seven (7) business days for individuals seeking services who are not in urgent or emergency need.

System of Care for Children, Youth, and their Families – means a community support system for children or youth with mental health problems and their families, which is developed through collaboration in the administration, financing, resource allocation, training, and delivery of services across all appropriate public systems. Each child's or youth's mental health services and mental health supports are based on a single, child-and youth-centered, and family-focused individual plan of care (IPC), encompassing all necessary and appropriate services and supports, which may be delivered by both public and private entities. Prevention, early intervention, and mental health services and mental health supports to meet individual and special needs are delivered in natural, nurturing, and integrated environments, recognize the importance of and support for the maintenance of enduring family relationships, and are planned and developed within the District and as close to the child's or youth's home as possible so that families need not relinquish custody to secure treatment for their children and youth.

Urgent Need – for consumers experiencing distress that will develop into a crisis state without intervention, but where there is not yet imminent threat of harm to the consumer or others. Distress may be defined as at risk behavior such as suicide, homicide, a recent major loss, or a severe decompensation of functioning. Services must be provided within the same day of consumer presentation.